

MONTANA BOARD OF VETERINARY MEDICINE

EUTHANASIA AGENCY CERTIFICATION

THIS IS AN INFORMATION SUMMARY SHEET ONLY. THE APPLICANT IS RESPONSIBLE FOR READING THE COMPLETE STATUTES AND RULES PRIOR TO MAKING APPLICATION. APPLICATIONS MUST BE APPROVED BY THE BOARD THROUGH THE MAIL. AVERAGE APPROVAL/DENIAL TIME, AFTER RECEIPT OF ALL REQUIRED DOCUMENTATION, IS TWO WEEKS.

A. REQUIREMENTS FOR CERTIFICATION:

CERTIFIED EUTHANASIA AGENCY

Application must include:

1. Documentation of passage of an inspection by a board-approved inspector. Contact Board office to schedule an inspection.
2. Copy of completed Form 224 application sent to the Drug Enforcement Agency 115 Inverness Dr East Englewood, CO 80112 1-800-326-6900 www.deadiversion.usdoj.gov **DEA number must be reported to the Board when received.**
3. List of CET's and veterinarians employed by agency including initial employment date.
4. Indication of Certified Euthanasia Technician in Charge.
5. 6 copies (plus original) of the completed application prescribed by the board and required supporting documents accompanied by the application fee of \$150 (non-refundable) to the Board office.

Send applications to:
MONTANA BOARD OF VETERINARY MEDICINE
CHERYL BRANDT, PROGRAM MANAGER
301 S PARK, ROOM 430
PO BOX 200513
HELENA MT 59620-0513
(406) 841-2394
E-Mail: dlibsdrvvet@state.mt.us
Website: www.discoveringmontana.com/dli/vet

MONTANA BOARD OF VETERINARY MEDICINE

P.O. Box 200513
Helena, Montana 59620-0513
(406) 841-2393 FAX (406) 841-2305
<http://discoveringmontana.com.dli/vet>

Application for: ☐ Certified Euthanasia Agency

Licenses are **non-transferable from one location to another or from one owner(s) to another**. The new agency must be inspected and must meet the standards for operation as set by the Board.

Part 1.

1. BUSINESS ENTITY: ☐ Governmental Agency ☐ Non-profit Corporation ☐ Other
2. BUSINESS ENTITY NAME: _____
3. FEDERAL TAX ID# _____
4. BUSINESS ADDRESS (Physical Address): _____
Street including # City State Zip
5. BUSINESS MAILING ADDRESS: _____
P. O. Box or Street City State Zip
6. BUSINESS TELEPHONE NUMBER (____) _____ (____) _____
Business Fax
7. BUSINESS E-MAIL ADDRESS _____
8. LIST ANY DBA _____

Part 2.

9. LIST THE AGENT FOR SERVICE:

Last First MI Phone # SS#

Part 3.

10. _____
(Certified Euthanasia Technician-in-Charge) License Number
11. TELEPHONE # (____) _____ (daytime) (____) _____ (evening) E-MAIL _____
12. Has any legal or disciplinary action been filed against the agency?
If yes, attach a detailed explanation. ☐ Yes ☐ No
13. Has a licensing agency ever taken adverse or disciplinary action against the euthanasia agency certificate? If yes, attach a detailed explanation. ☐ Yes ☐ No

14. Has a complaint ever been made against the euthanasia agency alleging unethical behavior or unprofessional conduct? If yes, please explain? ☐ Yes ☐ No

15. Has the euthanasia agency ever had a certification denied, revoked, or suspended? If yes, give details. ☐ Yes ☐ No

16. Has the euthanasia agency certification ever been forfeited or surrendered? If yes, give details. ☐ Yes ☐ No

Part 4. PLEASE LIST ALL LICENSED AND UNLICENSED PERSONNEL WORKING IN THIS FACILITY:

Last Name	First Name	Employment Start Date	SS#	License #	Position

AFFIDAVIT

I authorize the release of information concerning my education, training, record, character, license history and competence to practice, by anyone who might possess such information, to the Montana Department of Labor and Industry, Healthcare Licensing Bureau.

I hereby declare under penalty of perjury the information included in my application to be true and complete to the best of my knowledge. In signing this application, I am aware that a false statement or evasive answer to any question may lead to denial of my application or subsequent revocation of licensure on ethical grounds. I have read and will abide by the current licensure statutes and rules of the State of Montana governing the profession. I will abide by the current laws and rules that govern my practice.

Legal Signature of Applicant

Dated

Subscribed and sworn to before me this _____ day of _____, _____ at

City/State

Signature of Notary Public

SEAL

Notary Public Printed Name

For the State of

My commission expires _____, _____.

POWER OF ATTORNEY FOR DEA ORDER FORM - EUTHANASIA AGENCY

Montana Board of Veterinary Medicine
301 S Park Avenue 4th Floor, Helena MT 59620-0513
<http://www.discoveringmontana.com/dli/vet>

Euthanasia Agency Name _____

Address of Registrant _____

City, State, and Zip _____

DEA Registration Number _____

I, _____, (name of person granting power), the undersigned, who is authorized to sign the current application for registration of the above-named registrant under the Controlled Substances Act or Controlled Substances Import and Export Act, have made, constituted, and appointed, and by these presents, do make, constitute, and appoint _____ (name of attorney-in-fact), my true and lawful attorney for me in my name, place, and stead, to execute applications for books of official order forms and to sign such order forms in requisition for Schedule I and II controlled substances, in accordance with section 308 of the Controlled Substances Act (21 U.S.C. 828) and part 1305 of Title 21 of the Code of Federal Regulations. I hereby ratify and confirm all that said attorney shall lawfully do or cause to be done by virtue hereof.

(Signature of person granting power)

Witness: _____

I, _____ (name of attorney-in-fact), hereby affirm that I am the person named herein as attorney-in-fact and that the signature affixed hereto is my signature.

(Signature of attorney-in-fact)

Witness: _____

Signed and dated on the _____ day of _____, 200____.

Notice of Revocation: The foregoing power of attorney is hereby revoked by the undersigned, who is authorized to sign the current application for registration of the above-named registrant under the Controlled Substances Act or the Controlled Substances Import and Export Act. Written notice of this revocation has been given to the attorney-in-fact _____ this same day.

(Attorney-in-fact Name)

(Signature of person revoking power)

Witness: _____

Witness: _____

Signed and dated on the _____ day of _____, 200____.

☐ Initial ☐ Annual ☐ Other

2. CERT. NUMBER

4. E-MAIL ADDRESS

6. CET IN-CHARGE

7. CET CERTIFICATION NUMBER _____

8. DATE OF REPORT _____

The following inspection is conducted in compliance with the rules of the State of Montana Board of Veterinary Medicine and is for purposes established by these rules only. This inspection does not imply, nor does it intend to imply, ratification of any agency's practices regarding federal, state, local or regulatory agency authority.

10. Agency Staff (Include all CET's and Veterinarians)

[illegible]

A. AGENCY FACILITY

- | | | | |
|-----|--|------------------------------|-----------------------------|
| 1. | Is the agency area clean and regularly disinfected? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. | Are required agency & staff current licenses posted? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. | Agency has specific area designated for euthanasia with room for 2 people? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. | Lighting in the euthanasia area is bright and even? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5. | Euthanasia area is adequately ventilated? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 6. | Floor of euthanasia area provides for dry, non-slip footing? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 7. | Area has table or work area for handling animals during euthanasia? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 8. | Area has cabinet, table, or workbench for placement of equipment? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 9. | Agency has DEA approved drug storage? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 10. | Temperature and environment in storage cabinet adequate to assure proper keeping of approved euthanasia drugs? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

B. MATERIALS REQUIRED (ALL IN WORKING ORDER)

- | | | | |
|----|--|------------------------------|-----------------------------|
| 1. | Needles –Medical Quality 22g, 20g, 18g lengths 5/8" –1 1/2"? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. | Syringes 3cc, 6cc, 12 cc, 20cc? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. | First Aid Kit? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. | Tourniquets? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5. | Electric Clippers – No. 40 Blade? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 6. | Stethoscope? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 7. | Humane Restraint Devices? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 8. | Towels? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 9. | Disinfectant? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

C. RECORD KEEPING

- | | | | | |
|----|--|--------------|------------------------------|-----------------------------|
| 1. | Is the agency registered with the D.E.A.? | 21CFR1301 | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. | Is the D.E.A. Biennial Inventory current & available? | 21CFR1304.11 | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. | Is D.E.A. form 222 properly executed? | 21CFR1305.06 | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. | Are necessary Power of Attorney forms in place? | 21CFR1305.07 | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5. | Are Schedule II records filed separately in chronological order, by name and strength, for each order received ? Records show: | 21CFR1304.04 | | |
| | A). Date of receipt? | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| | B). Source of receipt? | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| | C). Invoice number? | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 6. | Are Schedule II records filed separately in chronological order, by name and strength, for each dose administered ? Records show: | 21CFR1304.04 | | |
| | A). Date? | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| | B). Species? | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| | C). Dosage Administered? | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| | D). CET or Vet who administered? | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

- | | | | | |
|-----|---|-----------------|------------------------------|-----------------------------|
| 7. | Are euthanasia drug containers labeled with concentration & volume? | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 8. | Are controlled substance records maintained for 2 years? | 21CFR1304.04 | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 9. | Does agency maintain perpetual inventory on C-II drugs? | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 10. | Is the perpetual inventory reconciled on a regular schedule? | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 11. | Have there been shortages or losses of CS in the past year? | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 12. | If so, was the loss reported to DEA & Board of Vet Med? | CSA section 301 | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

D. DISPOSAL

- | | | | |
|----|--|------------------------------|-----------------------------|
| 1. | Used needles and syringes are disposed of in such a manner that their re-use is impossible and according to 29 CFR1910.1030 and 75-10-1005, M.C.A? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. | Disposal records are maintained for any expired or unwanted drugs? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. | Expired/unwanted drugs disposed according to Code of Federal Regulation? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. | Carcasses disposed according to Title 75 Chapter 10, MCA? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

If there are any violations noted on this report the Euthanasia Technician in Charge must respond in writing to the Board of Veterinary Medicine office regarding all corrective action taken by the agency for all violations. If a response is not received in the specified time frame the compliance specialist will file a complaint with the Board of Veterinary Medicine for possible disciplinary action during a regularly scheduled screening panel meeting. You will be notified in writing of the scheduled meeting date and be required to respond to the licensing violations.

Compliance Specialist Recommendations:

Required actions from this report:

Date required action must be completed: _____

DATE

COMPLIANCE SPECIALIST SIGNATURE

I ACKNOWLEDGE THAT THIS REPORT HAS BEEN EXPLAINED TO ME AND I HAVE RECEIVED A COPY OF THIS REPORT.

EUTHANASIA TECHNICIAN IN CHARGE SIGNATURE

DATE